

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-009033

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 542 Registrar's No. 229

FILED MAR 7 1962

1. PLACE OF DEATH
a. COUNTY

St. Louis

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTYb. CITY (If outside corporate limits, give TOWNSHIP only)
OR TOWN FergusonLength of stay in lb
1 Mo.c. CITY
OR TOWN St. LouisInside Limits
Yes ☒ No ☐c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR INSTITUTION Hilltop Nursing HomeInside Limits
Yes ☒ No ☐d. STREET ADDRESS (If outside, give location)
5538 Greer AvenueReside on Farm
Yes ☐ No ☒3. NAME OF DECEASED
(Type or print)First William

Middle

Last Brockman4. DATE
OF DEATH

Month

Day

Year

1 15 19625. SEX
Male6. COLOR OR RACE
White7. Married ☒ Never Married ☐
Widowed ☐ Divorced ☐8. DATE OF BIRTH
5-2-719. AGE (last birthday)
90IF UNDER 1 YEAR
Months Days Hours Min.IF UNDER 24 HR
Months Days Hours Min.10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Cabinet Maker (ret.)10b. KIND OF BUSINESS OR INDUSTRY
St. L. Pub. Service11. BIRTHPLACE (City and state or country)
Germany12. CITIZEN OF WHAT COUNTRY
U.S.A.

13a. FATHER'S NAME

Unknown

13b. MOTHER'S MAIDEN NAME

Hegedorn

14. NAME OF HUSBAND OR WIFE

Minnie Brockman15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)
No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Mrs. Minnie Brockman, 5538 Greer18. CAUSE OF DEATH (Enter only one cause per line
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cerebral ThrombosisINTERVAL BETWEEN
ONSET AND DEATH
1 weekConditions, if any,
which gave rise to
above cause (a),
stating the under-
lying cause last.

DUE TO (b)

DUE TO (c)

332XPART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal
disease condition given in PART I (a)PART III. If deceased was female was
there a pregnancy in last 90 days.☐ Yes ☐ No ☐ Unknown19. WAS AUTOPSY
PERFORMED?
YES ☐ NO ☒20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF
INJURYHour
a.m.
p.m.

Month, Day, Year

20d. INJURY OCCURRED
WHILE AT WORK ☐
NOT WHILE AT WORK ☐20e. PLACE OF INJURY (e.g., in or about home,
farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from

Dec 17 - 1961to Jan 15 - 1962and last saw him alive on Jan 15 - 1962

Death occurred at

10:30

p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

22c. DATE SIGNED

23a. BURIAL, CREMATION,
REMOVAL (Specify)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county)

(State)

24. FUNERAL DIRECTOR

ADDRESS

25. DATE RECD. BY LOCAL REG.

26. REGISTRAR'S SIGNATURE

Cremation 1-18-62 Oak Grove Crematory St. Louis County Mo.1-17-62Drehmann-Harral, 1905 Union Bl.

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

INSTEAD OF

DATE AMENDED

BY AFFIDAVIT OF

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO.

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Warren A. Conner

Licensed Embalmer No. 3534

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.